Illinois Insurance Facts

Insurance Coverage for Autism

Illinois Department of Insurance

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Note: This information was developed to provide consumers with general information and guidance about insurance coverages and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

For children diagnosed with autism, early intervention and continued treatment is critical.

Beginning December 12, 2008, all individual and group health insurance policies and HMO contracts must abide by the provisions of Public Act 95-1005 (215 ILCS 356z.14). This new Illinois law provides coverage for the diagnosis and treatment of autism spectrum disorders for children under 21, establishing an annual benefit of $36,000 for services provided pursuant to this Act. Here are the basic facts about the new law.

When Will Coverage Under the Law Take Effect?

The law became effective December 12, 2008. Any policy issued, delivered, amended or renewed after this date must include autism coverage required by the law.

If you are covered by a **group** health insurance policy (*i.e.*, through your employer) issued before December 12, 2008, you may have to wait until the date that the policy is amended or renewed before your child is eligible for autism coverage under this law. Check with your group or your insurer to find your policy's renewal date.

If you are covered by an **individual** health insurance policy issued before December 12, 2008, you may have to wait until the policy's renewal date before your child is eligible for autism coverage under this law. Check with your insurer to find your policy's renewal or anniversary date.

Who Must Offer Autism Coverage?

All individual and group health insurance policies and HMO contracts (and voluntary health service organization contracts) must abide by the new law. Health coverage provided to state, county, and municipal employees (and employees subject to the Schools Code (105 ILCS 5/1-1 *et seq.*)) must also provide the autism benefits.

The Autism Law Does Not Apply to:

- Self-insured, non-public employers.
- Self-insured health and welfare plans, such as union plans.
- Insurance policies or trusts issued in other states.

NOTE: For HMOs, the law does apply to contracts written outside of Illinois if the HMO member is a resident of Illinois and the HMO has established a provider network in Illinois. To determine if your

HMO coverage is required to provide treatment for autism, contact the HMO or check your certificate of coverage.

The law does not change the autism coverage provided by public health care programs such as FamilyCare and All Kids. Contact the specific program for more information about its autism coverage.

Who is Covered?

Children under the age of 21 who have health coverage through an individual or group policy, as described above, will receive coverage for the diagnosis and treatment of autism spectrum disorders.

What is Covered?

The new law requires coverage for the diagnosis of autism spectrum disorders. For individuals diagnosed with an autism spectrum disorder, the new law also requires coverage for the following treatment:

- Psychiatric care;
- Psychological care;
- Habilitative or rehabilitative care (counseling and treatment programs intended to develop, maintain, and restore the functioning of an individual); and
- Therapeutic care, including behavioral, speech, occupational, and physical therapies addressing the following areas:
  - Self-care and feeding
  - Pragmatic, receptive, and expressive language
  - Cognitive functioning
  - Applied behavioral analysis, intervention, and modification
  - Motor planning
  - Sensory processing

Insurance companies may not impose dollar limits, deductibles or copayments for the diagnosis or treatment of autism which differ from the dollar limits, deductibles or copayments established for physical illness.

All services covered by this new law must be prescribed by a physician. However, some of the services may be delivered by certified or licensed professionals who are not physicians (*e.g.*, speech therapists, physical therapists, and occupational therapists). Insurance companies are required to cover medically necessary care provided by these professionals.

What are the Limits of Coverage Under the New Law?

This law requires insurance companies to provide coverage for the diagnosis and treatment of autism up to an annual limit of $36,000. An insurance company may provide coverage beyond this limit, but is not required to do so by this law.

- Insurance companies are prohibited from limiting the number of visits to a physician or other service provider.
- Treatments for conditions not diagnosed as autism will not apply to the $36,000 annual limit.

The Illinois Serious Mental Illness Mandate (215 ILCS 370c) requires group insurance policies covering more than 50 employees and all group HMO contracts to cover certain autism treatments. Benefits provided by this new autism law are in addition to benefits provided by the Serious Mental Illness Mandate. The Serious Mental Illness Mandate benefit limits are not altered by Public Act 95-1005. For more information about the Serious Mental Illness Mandate, please see the Department's fact sheet on Mental Health Coverage at http://www.idfpr.com/doi/HealthInsurance/mental_hlth.asp.

Insurance companies may not categorize benefits historically covered under the Serious Mental Illness Mandate as benefits now covered under this new law.

Can Insurers Refuse to Cover Individuals with Autism?

Group health insurance policies are not allowed to refuse enrollment based on health status.

For **individual** policies, Illinois law currently allows insurance companies to reject an application for health insurance based on health status. However, beginning June 1, 2009, a new Illinois law (Public Act 95-0958) will allow individuals with health insurance policies that provide dependent coverage to elect coverage for dependents up to age 26, regardless of a dependent's health status. For more information on this law, please see the Department's fact sheet on Dependent Coverage (http://www.idfpr.com/DOI/pressRelease/pr08/HB5285DependentCoverage.pdf).

Is Autism Subject To Pre-Existing Condition Limitations?

Yes. Illinois law allows insurance companies to exclude coverage for pre-existing conditions, including autism, for up to 2 years. Specific exclusion periods vary based on individual circumstances, including the type of policy and an individual's history of health insurance coverage. For more information, please see the Department's fact sheet on HIPAA and pre-existing conditions (http://www.idfpr.com/DOI/HealthInsurance/HIPAA_preexisting_cond.asp).

Illinois law governing pre-existing condition limitations for dependent children will change in significant ways due to the new dependent coverage law (P.A. 95-0958). For more information on these changes, please see the Department's fact sheet on Dependent Coverage (http://www.idfpr.com/DOI/pressRelease/pr08/HB5285DependentCoverage.pdf).

NOTE: Individual and group HMO plans may not impose pre-existing condition exclusions, but may limit coverage of pre-existing conditions through the use of deductibles and co-payments, for a period of up to 12 months.

Can Insurers Deny Claims Based on Medical Necessity?

Like coverage for other conditions, coverage for the treatment of autism is subject to insurance company determinations of medical necessity. An insurance company may deny coverage for a certain treatment if the treatment is not medically necessary or does not result in improved clinical status.

A treatment must be considered medically necessary if it is reasonably expected to:

- Prevent the onset of an illness, condition, injury, disease or disability;
- Reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability; or

- Help an individual achieve or maintain maximum functional activity in performing daily activities.

If an insurance company denies a claim based on an adverse determination of medical necessity, you may appeal the company's decision. The company's decision must be based on a determination made by a physician with expertise in the most current and effective treatments for autism spectrum disorders.

Appeal procedures and applicable state laws differ for HMOs and insurance companies. For more information, please see the Department's fact sheet on Medical Necessity (http://www.idfpr.com/DOI/HealthInsurance/Medical_Necessity.asp).

For More Information

Call the Department of Insurance Consumer Services Section at (312) 814-2427 or our Office of Consumer Health Insurance toll free at (877) 527-9431 or visit us on our website at http://insurance.illinois.gov.